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How One's Cultural View of Obesity Affects Care Giving

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This is to certify that **Marietta Kramper Farris** has successfully defended her Graduate Project entitled **"How One's Cultural View of Obesity Affects Care Giving"** and fulfilled the requirements for the Master of Arts in Nursing degree.

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Abstract

As the United States faces the challenge of obesity it is important to understand the cultural aspects of caring for these patients. Leininger's Transcultural Nursing Theory is used as a framework for the development of an educational program for health care professionals. The obese patients receiving care should be able to count on their care givers to appreciate the biases, stigmatization and discrimination of the culture in which they live. A review of the history of cultural views of obesity and thinness is used as a starting point. An in-depth review of related research is presented to detail bias, stigmatization, and discrimination faced by the obese in our culture and is used to develop the educational program. A program outline, including key talking points, group activities and handout are included.

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Acknowledgments

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Cultural view of obesity

Chapter One: Introduction

The numbers show that the United States is facing the challenges of obesity (Healthy People, 2001). Obesity is now ranked as the leading cause of preventable deaths within the U.S. (Komesaroff & Thomas, 2007). It is unlikely that any American has not heard or read something about this health issue in the last year. It is highly likely they themselves or someone they know deals with being overweight or obese in a culture where "thin" is in and "chubby" is undesirable (Beller, 1977; Seid, 1989; Hesse-Bider, 1996; Park, 2005; Field, Barnoya, & Colditz 2002,).

Hilde Bruch, well known for her work with eating disorders and obesity and author of "The Golden Cage (McgovernLibrary, 2008)," wrote in 1948:

> A clinician of the last century divided obesity into three stages, known respectively as the enviable, the comical, and the pitiable. This is unusual language for medical classification. It illustrates well the peculiar place which obesity occupies in medicines. It has been said that there are few bodily conditions that cause quite as much unhappiness and misery as the unlovely state of corpulence. The suffering of the obese person is of a different order from that in other physical ills. It is not experienced as pain or

> bodily discomfort, but in a person's relationship to his fellow man. (Bruch, 1948)

With these words in mind, a brief history of how obesity and thinness has been viewed over time will be given as a background along with information on the discrimination and stigmatization obese people may have experienced at the hands of the general public and health care workers. To better prepare health care professionals caring for these patients an educational program has been developed using Leininger's Transcultural Nursing Theory. This theory provides the framework for exploring an overall cultural view of obesity and one's own beliefs about the issue.

Approximately 133.6 million people are considered to be overweight (Body Mass Index (BMI)of 25 to 29.9) or obese (BMI greater than or equal to 30). Body Mass Index is a formula that combines weight and height. It is commonly used as it takes into account both height and weight (Field, Barnoya, & Colditz, 2002). The formula for BMI is weight in kilograms, divided by the height in meters, squared. The above number is two-thirds of the US adult population (Healthier You, 2008). If one believes these numbers, one may also question how it can be true that the culture still values thin when so many of its members are overweight and obese. Cultural values and beliefs are developed over time and do not change overnight. In spite of the numbers the American public still holds "thin" as in. Americans spent an estimated 46 billion dollars in 2004 on diet products and

self-help books (Forbes, 2005). While many people diet for health, many also diet related to the desire to "look good" as defined by the culture's standards (Hesse-Bider, 1996). Those standards are framed by what is shown in the media, fashion and beauty industry, and people's own understanding as to what is culturally acceptable.

To understand the complex nature of the Western European culture's attitudes about obesity, one needs to first look at what makes up culture and how it shapes one's world view. Leininger uses the following definitions of culture, "Culture refers to the learned, shared and transmitted knowledge of values, belief, lifeways of a particular group that are generally transmitted intergeneration and influence thinking, decision and actions in patterned or in a certain ways"(Leininger & McFarland, 2002, p. 47).

Thus the Western European view of obesity is shaped by what we have learned and believe about being obese. Madeleine Leininger understands the importance of including and understanding cultural beliefs in care given to patients served by nursing and other professions. She began the development of transcultural nursing along with the Sunrise Model in the 1950's, with the model being refined up to 1985. The Sunrise Model allows care professionals to provide holistic care by preparing them to such elements as social structure, ethnohistory, genetics, religion, spiritual, ethics, language uses, environment, politics, family structures, arts and other ideas as influencer of human care (Leininger & McFarland, 2002).

Transcultural nursing theory points to the need to understand one's own cultural beliefs. To understand why this is important one could think of the phase "looking at the world with rose colored glasses." Just as rose colored glasses impacts how the wearer views things around them, so one's cultural beliefs and values, impacts how one reacts and sees the world around them. As caregivers, we are not asked to give up our culture when using Leininger's theory, but explore our culture so that we understand how it filters what we see and understand about others. This helps adjust our "rose colored glasses" and alerts us to different ways of viewing and helping our patients.

There is no disagreement that obesity is a major public health concern. Obesity has been long linked to heart disease, hypertension, diabetes, musculoskeletal conditions, and sleep apnea (Field, Barnoya & Colditz, 2002). Those living with obesity are thus in need of both preventative, routine and acute health care. Many, however, do not receive the required care related to any number of factors including body shame and negative past experiences with health care related to their size (Friedman, 2008).

Studies have found that the obese person is the victim of bias and discrimination, even in health care (Friedman, 2008). It is human nature to avoid situations and events that are stressful and uncomfortable (Gilbert & Miles, 2002). Education on the experiences of the obese patient both within and outside of health care settings can only make health care workers better

prepared to provide less stressful and more comfortable care for the obese patients. It is in understanding the biases held by the culture and more importantly biases held by oneself that the first step of motivation for change can take place.

Chapter 2 Literature Review

History of Obesity in United States Culture

Obesity has been present for years in human society as documented in the arts and writings of early philosophers (Beller, 1977). The cultural view of the obese person has changed over time with periods when the round full figures of people have stood for beauty, prosperity, good health or conversely, when that same body type has been viewed as unattractive or reflecting gluttony and an unhealthy life style. It is said the Spartans ostracized a man for being fat (Beller, 1977). Socrates may have been the first to practice "jazzercise", as it is reported he danced each morning to keep his figure in check (Beller, 1977). These events and ways of viewing obesity all play a part in the development of how the obese person is seen in the prevailing American culture today.

In human history there are taboos and rituals around food, including how it is prepared, how and when it is eaten, and even who eats what. It should not be difficult for anyone to understand that food holds meaning beyond essential nutritional value. Food and eating are related to religious beliefs, cultural rituals and are tools used for the development of relationships (Leininger & McFarland, 2002). In some cultures food, both in the amount and how it is prepared, is a measure of prestige (Powdermaker, 1997). Taboos about watching others eat may well go back to the times of food scarcity when those with out may have looked at those eating with a plea in their eyes

saying 'how can you not share with me' (Mead, 1997)? Food is central to events such as births, marriages, death and other celebration of all types. Cultural and family traditions determine what types of food and the amount of food served at this events. Leininger and McFarland (2002) give food seven universal functions:

- Food has been used universally since the beginning of homo sapiens to provide essential nutritional needs to help people maintain body functions and energy and survive.
- Food has been used to establish and maintain social and cultural relationships with friends, kinsfolk, strangers and others.
- Food is used to assess social relationships or interpersonal closeness or distance between people.
- Food is used to cope with emotional stresses, conflicts, and traumatic life events.
- Food is used to reward, punish and influence the behavior of others.
- Food is used to influence the political and economic status of individual or group.
- Food is used to access, treat and prevent illnesses or disabilities of people transculturally.

It is important to keep the complex uses of food in mind when working with the obese patient, as food and eating may hold any one of a number of complex emotional feelings and bearings to the patient.

The image of the poor hungry person with their nose pressed to the window of a restaurant as a well-fed individual or even obese person eats has been used in pictures, films, and books to arouse human compassion (Mead, 1997). The compassion is not directed to the person eating who may possibly be suffering from hypertension, back pain, or heart disease; no it is directed to the hungry face in the window. The person eating may well be viewed as the villain or the object of a joke about his size. The obese person in this scene may well be the same person that was told to clean their plate or have no dessert. "Clean your plate or no dessert" was a common message given to children in the 1950's and 1960's (7B nursing staff, personal communication, November 11, 2008). Studies on cleaning your plate had not yet been done, thus parents did not know the harm they were doing to their children. It has been found that children who belong to the clean plate club are more likely to ask for more food when eating outside of their own home (Wansink, Payne, & Werle, 2008). Research has shown that people will eat more calories if given a large serving size (Watkins, 2008). A study has shown people on average make 219.1 decisions about food a day (Payne & Wansink, 2007).

The obese person in this well known scene may also have been the one that was told the food that is good for you doesn't taste good and the good tasting foods are not so good for us (Mead, 1997). Is this the same person that fell into the pattern of having between meal snacks and beverages that provide little nourishment (Mead, 1997)? It is hard to say but it may

very well be the same person that is affected by the cultural view of obese held by many in this country.

The US's first fashion magazine, Godey's Lady's Book, appeared in 1828 showing young, pretty, even willowy models. J. A. Brillat-Savarin, writer of *The Physiology of Taste and International Dining with Spice Islands* and whose views on food and obesity are consider as classic works, wrote in 1828 of the death of a friend from a vinegar and water diet she started after being teased about getting fat (Library Thing, 2006; Seid, 1989). The view that obesity is not acceptable can be seen in other writing during this time period. The Newark Daily Advertiser held this comment in 1838, "Obesity is a deadly form to genius; in caneous and unwieldly bodies the spirit is like a gudgeon in a large frying pan of fat, which is either totally absorbed or tastes of nothing but lard"(Seid, p. 62). The 1850's saw slenderness lose some favor as the American view of a "rosier, healthier, plumper, and stronger than her fashionable sisters" took hold (Seid, p. 67). While Venus, the goddess of love and beauty, was still being portrayed with a full moon face, round full hips and thick with flesh, the shift was occurring in public opinion (Beller, 1977).

The desire for beauty did not stay with the round shapes and fullness into the 1900's. In 1908, *Vogue* was using phrases such as "How slim, how graceful, how elegant women look" (Seid, 1989, p. 81). Slender was not only seen as an attribute of beauty describing women, but it was also required for men as reflection of the newly industrialized nation. This industrial

nation called for new slimmer bodies that matched the slim powerful machines. More slender bodies began to represent youth and fun. The affect of this new definition of size even affected the president. President Taft weighed 355 pounds at the time of his inauguration in 1909(The White House, 2008). He was called a big man and worked to decrease his weight so not to be called fat and to stop the fat jokes that surrounded his presidency (The White House, 2008).

Bruch (1948) made the following observation about obesity in the 1940's. She reported obesity to be the cause of ridicule and humiliation. Younger obese people were noted to be withdrawing from activities related to not wishing to be embarrassed by their size and appearance (Bruch, 1948). Bruch (1948), at a presentation of her work, goes on to use a remark by poet Ogden Nash to reflect the 'contemporary' view of body size for women in this time period: "Some ladies smoke too much and some ladies drink too much and some ladies pray too much, but all ladies think they weigh too much."

The 1950's clearly were a pivotal time in the confusing world of the American weight battle. This was a time of abundance in food, including fast food, fine dining, and prepared food such as frozen dinners. The modern diet food industry finds it roots here. Sales of diet soft drinks showed massive growth between 1952 and 1959 (Bellis, 2006). It was also a time when dieting and or size became a topic of books, magazine articles and television shows (Seid, 1989). Jack LaLanne was on the TV talking exercise for health and weight.

Vogue and other magazines showed the woman of the day that upward mobility was possible with the correct clothes and shape (Seid, 1989).

Even men were impacted at this time (1950's), more related to health issues than fashion as the affects of obesity were starting to be related to a shorter life and heart disease(Field, Barnoya, & Colditz, 2002). Louis I. Dublin, who worked for Metropolitan Life Insurance Company (MLIC), reported his study that correlated being overweight with mortality. Though his data included only information for people who held life insurance policies and did not deal with average weight but ideal weight, medical professionals used his information to explain why heart disease had become the number one cause of death in the nation (Seid, 1989). Physical causes for obesity were being ruled out at this time; heredity and glandular cause for being overweight were linked to only 1 in 200 cases of obesity (Seid, 1989). Obesity was viewed as a preventable condition (Field, Barnoya, & Colditz, 2002).

Dieting and exercise became the answer on how to address obesity. The overweight person needs to eat less and exercise more. This fits with the view that weight loss is just that easy, burn more calories then you consume. Those unable to do this on their own and could afford membership fees may look for help from support groups such as TOPS, Overeaters Anonymous and Weight Watchers. These three groups all started in the late 1950's and early 1960's as part of a growing belief in group therapy and support (Seid, 1989). Natalie Allon completed

observational research on one of these groups in the 1970's and found them to be comparable to quasi-religious experiences. She noted dieters labeled being overweight as sinful deviation (Hesse-Bider, 1996).

It should also be noted that the demand of groups and programs to aid with weight loss were high but the programs were unregulated until the late 1990's (Womble, Wang, & Wadden, 2002). Programs and groups varied in the type of approaches but focus on diet, exercise and lifestyle changes with major focus on diet(Womble et al ., 2002). Medical care was not included in these groups although the diets and exercise plans may have been developed by medical professionals (Womble et al., 2002). These programs and groups often sight past clients with very successful weight loss but fail to share information on the true cost of the program and the amount of weight that is regained after one year of ending the program(Health Management Resources, 2008; Womble et al ., 2002).

These groups provide support for calorie intake control at the same time modern conveniences reduced the physical work and exercise required of Americans. The car replaced walking, automatic washers and dryers replaced all day wash days, construction equipment reduced the demand for physical labor, modern factories offered more push button jobs. Leisure time activities also changed. Television provided entertainment with out leaving the house. More people were moving to the city and sprawling urban neighborhoods where limited sidewalks, bike trails and more time to commute to work decrease the

availability for exercise (Marvin & Medd, 2005). Even as the Kennedy Administration pushed fitness with the development of the Council on Physical Fitness the weight of the American public was on the rise.

The 1960's was a time of continuing messages about weight. Dublin's work now for MLIC lowered the ideal body weight for all age ranges (Seid, 1989). The National Academy of Sciences lowered caloric intake recommendations twice in the 1960s (Seid, 1989). Obesity was seen by some as 'malnutrition' defined as the pathological state of being in excess of one or more essential nutrients (Khongsdier, 2003).

The use of the term malnutrition added to the complex cultural view of obesity. Those suffering from malnutrition were seen as poor, dirty and ignorant and many of these characteristics were past on with the malnutrition label (Seid, 1989). Malnutrition is often a condition of poverty (Rector & Johnson, 2004). The reasons for being poor can be seen as including such things as lack of skills to find and hold a job (Rector & Johnson, 2004). The poor are often pictured in worn clothing and simple housing. The nation's attention was focused on malnutrition in 1907 when Robert Chapin investigated the living conditions of the poor in New York City (Lovett, 2005). This was a time of unemployment, high food prices and food riots in some cities. The first phases of World War I (1914-1915) showed America pictures of starving Armenians in poor living conditions (Lovett, 2005). The Great Depression also framed malnutrition and hunger as a condition of the poor. People took

pride in being able to provide for their families, those that could not stood in bread lines (H. Kramper, personal communication, 11/11/2008).

Youth was the new driving force for those coming of age in the 1960's and for those wishing to be part of the 'Pepsi Generation.' Thinness and youth were seen as going hand in hand. Twiggy was the modern model, shocking thin for her time weighing in at 90 pounds (Wolf, 1991). The fashions of the time showed shorter skirts and more skin. A sexual revolution was also happening, lead in part by the release of the first birth control pill, Enovid, in 1960 (Gadbaw, 1999). *Vogue* called 1965 the "Year of the Body" (Seid, 1989). The Barbie doll made the scene. Her body shape included: "exaggerated breast, impossibly long legs, non existent hips and a waist tinier than a Victorian lady's" (Hesse-Bider, 1996, p. 28). *Time* in 1968 called physical fitness 'a middle-aged obsession' and reported on the growing number of bikers, joggers, and gym classes.

The 1970's saw an ongoing focus on weight. Bruch and Stunkard, leading psychiatrists and obesity experts of the time, had the following comment in 1973; "The condemnation of overweight appears to on the increase, during the past twenty-five years, interest in weight reduction in our country has grown from a mild concern to an overriding preoccupation. "At present, interest in obesity almost assumes the dimensions of a national neurosis" (Seid, 1989, p. 166). The number of articles found in all types of publications; books, magazines, newspapers, columns, reached well above what had been seen in

the past. The famous Atkin's diet started to find a following in 1972, much to the dismay of the AMA's Council on Foods and Nutrition (Foster et al., 2003). Weight loss books for children made an appearance, *Yummers* and *100 Hamburgers: The Getting Thin Book*. Extreme diets and fasting were practiced by some as the means to lose weight with only temporarily giving up foods they enjoyed (Seid, 1989). The consumption of low-cal foods continued to increases at the same time the availability of foods high in sugar and fat was on the rise (Peralta, 2003). The 1970's showed the consumption of food eaten outside the home account for 27% of the total food budget for the average family (Cover story, 2007).

People began to be more interested in exercise as a means of healthy living and weigh control. James Fixx's *The Complete Book of Running* sold one millions copies in 1977(Seid, 1989). *Healthy People,* a national report focusing on the health state of the nation, was first published in 1979. It pointed out that each individual could reduce the risk for health issues by changing their own behaviors. Five habits were identified that could be changed, resulting in better health. These were: diet, smoking, lack of exercise, alcohol abuse, and use of antihypertensive drugs (Education and Welfare, 1979).

The weight of the average American continued to be going up as did the number of images of thinner people seen in the media. The size of models used for magazine covers and *Playboy* center folds decreased overtime (Katzmarzyk & Davis, 2001; Sypeck, Gray, & Ahrens, 2002). Fashion magazines, such as *Cosmopolitan,*

Glamour, Mademoiselle, and *Vogue* moved from using face or upper torso pictures on covers to using full body shots. The models were noted to have smaller body size during the 1980s and 1990s along with more skin seen and less fashions shown (Sypeck et al., 2002). *Playboy's* central fold models from the years 1978 to 1998 were found to be markedly underweight. Using information provided by the models themselves, 77.5% were more then 15% below their expected weights with 70% considered underweight (Katzmarzyk & Davis, 2001).

In 1985, only 8 states reported that 10% to 14% of their populations were overweight for a study done by the CDC. It should also be noted here that many states did not report weight information for this study. By 1989, 21 states reported this data. The CDC showed in 2007 only one state reporting 15% to 19% of the population overweight, while other states reported percentages much higher with some reported as high as 30% of the state population being overweight (Centers for disease control and prevention, 2008). Obesity numbers are on the rise of a rate of 5% per year and have doubled in the last two decades (Marvin & Medd, 2005). Not only are adults showing an increase in obesity, but children are beginning to tip the scales at higher numbers.

Sadly, several cities have begun to earn the honors of being labeled the fattest cities in the country. These cities include Philadelphia, Houston, and New Orleans (Marvin & Medd, 2005). As stated earlier, the reality of obesity appears to be related to poverty. The burden of obesity is often found in

lower socio-economic groups and more often by women in these groups (Marvin & Medd, 2005). African-American women show an obesity rate of 55.4 percent and white males have the lowest rate at 27.4 percent (Peralta, 2003).

Culture

Cultural patterns are learned. No one is born with prejudices or biases. These are learned from those around us, as we watch their behaviors, hear the language and words used, and are told the stories of our culture. In the past these stories were told generation to generation within the family or community. Now, mass media plays a significant role in the development of these concepts.

Cultures are developed by groups of people over time and include beliefs and behaviors reflective of the norms of the group. Cultural beliefs play a role in the development of rules and how they are carried out. Culture tells us what we can expect from the different people and events in our lives.

Traditionally, the United States' culture is a Western European culture that values technology, youth, and is seen as progressive (Leininger & McFarland, 2002). There are numerous subcultures found in the Western European culture of the U.S. Each person living within the U.S. will have a slightly different cultural view. This difference can include the foods one eats daily and at special events, clothes worn, the way new members to the family or group are greeted and accepted into the family. These differences are based on the life experience of each one person and framed by the cultural group. Yet, there

are common themes and practices that can be clearly identified as elements of the Western European culture of the United States.

The Protestant Work Ethic (PWE) influences how the American culture views those around us and the world. Sayings like 'people who work hard succeed' or 'anyone can pull themselves up by their boot straps' or 'the early bird gets the worms' and the famous line that 'anyone can grow up to be president' reflect the lay theory of the PWE. PWE has been used by some to justify how society and individuals treat unsuccessful groups of people (Levy, West, Ramerez, & Karafantis, 2006). A study Levy, West, Ramerez, and Karafantis (2006), conducted showed PWE can be the base for both intolerance and greater tolerance. This is said to be true related to the different meanings the PWE lay theory may hold at different points in ones life as well as on different subjects. The lay theory being what the common man would hold as being the PWE in his daily life. PWE lay theory is thus considered to have a basic meaning and additional meanings that may be added, understood or developed with related life experiences.

Thus PWE can frame a positive and supporting view for obesity using the belief that all people can have success if they work hard. The PWE opposite view of the obese person would be assuming the failure to lose weight or the reason they are overweight is their limited or lack of work to control their weight. Researchers have used surveys to show that the majority of people frame obesity as a question of 'individual

responsibility' (Peralta, 2003, p. 7). The obese may feel or be treated as if they are lazy regardless of their effort put forward to loose or control weight. The obese, unlike other people with illness or physical disabilities, do not receive much in the way of public compassion or respect (Komesaroff & Thomas, 2007).

The PWE holds a position on the individualism of the American people. Many would say the American dream is the individual determination of one's fate in life. Work hard; be true to yourself, take control of your life and you will have success. Holding these values to be true provides for psychological benefits and a life view where the individual holds a great deal of control over his/her own fate. Recognition for success in all areas of life is within the control of the person. The obese person who holds these beliefs will have a lower regard for themselves and may feel they deserve the rejection of employers, co-workers, family and public in general. The people, who are obese, in reaction to the cultural view of their size, see obesity as not a medical issue but simply as a moral failure of their own making (Komesaroff & Thomas, 2007). They have failed to do the hard work and can blame no one but themselves for their failure with dieting and controlling their weight (Quinn & Crocker, 1999).

It is interesting to note that a study done by C. Crandall and R. Martinez (1996) found a difference in the antifat attitudes of Americans and Mexicans. Mexicans showed less belief in the view that weight is controllable by the individual

and believed that exercise was a successful measure for weight management (Crandall & Martinez, 1996). These findings support the PWE view held strongly in the U.S. Individuals are responsible for the own fate (Peralta, 2003). Mexico culture is more socialist thus not finding blame with the individual responsibility for their weight. If the American cultural beliefs become ingrained in Mexican culture, it would be expected that blame and prejudice toward the obese will increase also in the Mexican culture (Crandall & Martinez, 1996).

The effect mass media has on cultural norms and beliefs has been studied by many researchers (Carr & Friedman, 2005 Crandall & Martinez, 1996; Gunther, 1998; Park, 2005). There is no denying many look to the media to find out what is the latest trend in fashion and even thinking. Albert Gunther(1998) conducted research to test if people believe media reports reflect what the public thinks about issues. The study was done with college students using two different topics of interest at the time of the study. Students were given slanted media reports on the issues. Those that read the positively slanted media coverage reported that the public viewed the issue positively. Those reading a negatively slanted report felt the public viewed the issues as was reported in the media coverage. The best point made by Gunther is that even those of us who may think we ourselves are not influenced by the media would agree that the media influences the thinking and belief of others.

Sung-Yeon Park (2005) summarizes the media's influence driving women to be thin by reviewing a number of research

projects on media's influence on cultural views. Park's focus is on the thin side of the weight issue, but much can be gained in reviewing the work with a focus on cultural development of body image and desired body shape. As early as 1939, the concept of how the media could influence the decision-making process was under study. Park (2005) points out that as early as 1974 researchers and theorists like Noelle-Neumann were putting forward the theory that people would remain silent about their own views if they thought they did not match what was held by the overriding views of the public as put forward by the media. Research also has shown that exposure to the 'thin idea' leads to an increased risk of eating disorders and the development of concerns about body shape (Park, 2005).

Body shame is a complex concept that reflects the experience of both the appearance of the body and the function of the body. Body shame is experienced for a wide range of people including those with physical deformities cause by birth defect, burns or other injuries, aging and eating disorders. Gilbert defined this as "an affective-defensive response to the threat of or actual experience of, social rejection or devaluation because one is unattractive as a social agent" (Gilbert & Miles, 2002, p. 7). The importance of social attractiveness is found in all cultures and is basic in all human beings.

Shame, like embarrassment and pride, is referred to as a secondary emotion that is developed as early as age two (Gilbert & Miles, 2002). How each of us sees our body and the feelings

we have about it is developed based on the social interactions we have within our culture. Cultural beliefs determine how members of the group look and react to such things as deformities, skin color, and weight. For example; deformities may be seen as payment for failure in a different life. In relationship to weight, one needs to understand the cultural concept of how the body is viewed. In Western European culture the person is seen as being in control of the body, owning it. This fits with the PWE view of determination and being able to control one's fate. For those that try to control their weight and fail to do so, in their minds their body has betrayed them. The obese person has lost control of their eating (Gilbert & Miles, 2002).

Body shame for obese individuals can also relate to a cycle of dieting, losing weight, regaining more weight than what was lost and starting a new diet. Dieting has many critics because most people regain all the weight they lost within 5 years or less (Wadden, Womble, Stunkard, & Anderson, 2002). The diet industry shows advertisements with pre and post pictures of the successful dieter. A patient who had undergone gastric-by-pass surgery for weight reduction related the following story on dieting to a group of nurses at the University of Minnesota Medical Center, Fairview in 2004.

> "I have tried many diets; I think all of them at some time in the last few years. I always regained the weight and more. I was a failure at dieting and ashamed of regaining the weight. I figured my body

> just didn't work like other peoples. Even as I was going into surgery for my by-pass, I figured I would not lose weight and keep it off. Why would I? I had failed at other diets and exercises, why would this work for me? My body was different and some how I would screw it up and gain weight again."

Other obese patients report feelings of hatred and loathsomeness toward their bodies (Bruch, 1997). Body shame is also related to activities that obese people have trouble doing such as walking long distances, playing physical games with their children or not being able to take part in sports (Goss & Gilbert, 2002). Obese people have reported feelings of having no control over their bodies, as it does not perform or do what they went it to do.

Body image is a term used widely in Western European Culture yet it is a vague concept (Bruch, 1997). Bruch (1997) writes that as early as 1935, Schilder defined body image as; "'the picture of our own body which is formed in our mind, that is to say the way in which the body appears to ourselves'" (p. 211). As one's body grows the body image changes to encompass the development of the body and the feedback about the body from those around us. Thus what one is told about our appearance and weight becomes a part of our body image (Bruch, 1997).

It is in the development of body image that cultural views as reflected by the family, friends and the media play critical roles. Body concept becomes part of one's total self-concept thus both are influenced by social context (Staffieri, 1967).

The desired body type in the United States is that of the mesomorph, and this preference can be seen in children as young as six years old (Staffieri, 1967). Mesomorphy is a body type showing predominance of muscle, bone and connective tissues and it is associated with aggressiveness and love of adventure (Butler, Ryckman, Thorton, & Bouchard, 2001). Unlike other elements of the human character body weight is always visible to others, open to input and feedback, invited and uninvited (Hess-Bider, 1996). Children in Staffieri's study showed accurate self-perception of body type by the age of 8. This may relate to the development of body dissatisfaction starting at this age. Body image has been found to be critical in the treatment of disorders such as anorexia and obesity.

Bruch (1997) reports it is not useful to show a newly diagnosed anorexic patient, a picture of themselves for they will not be able to 'see' how thin they are because their body image is in the way. Research done in 1983 by Cash, Cash and Butters, showed there was little connection to how attractive people are and how attractive they feel themselves to be (Cash et al., 1983). The same concept helps answer the common question related to how the obese patient could 'let themselves get so large?' Bruch (1997) related the story of an obese man who suffered with a number of complications of his obesity yet refused to take ownership of his size until one day when he stood in front of a mirror and was able to 'see' beyond his body image and acknowledge his true size.

Cultural view of obesity

Body image dissatisfaction in the obese is not always found to have clinically significant psychopathology nor do all obese people have body image dissatisfaction (Sarwer & Thompson, 2002). It has been noted people with onset of obesity in prepubescence have a noted increase in body image dissatisfaction. Degree of body image dissatisfaction can not be directly correlated to Body Mass Index (BMI) (Sarwer & Thompson). A study of English speaking adults between the ages of 25 and 74, found that the very obese(BMI between 35 and greater then 40) showed significantly lower self-acceptance scores then those of average weight and with BMIs of 25 to 29.9(Carr & Friedman, 2005). Body image dissatisfaction can lead to behaviors such as not being willing to leave one's home, weighing oneself repeatedly, changing how one dresses and moves, embarrassment in social situations, not having pictures taken, focusing on parts of ones body (often the abdomen), and taking on the personal behavior (i.e., jolly and happy) that one believes the culture associates with obesity (Gilbert & Miles, 2002).

One needs to keep in mind that America is a melting pot of races and cultures, thus it is important to study different racial/ethnic groups along with sex. A study done to evaluate the differences that may be present included European Americans, Latino Americans, and African Americans, both male and female. The outcome found that genders differ on global body image and weight concerns (Miller et al. 2000). Differences were noted between races, African Americans scored higher then the other

two groups on tools used to measure appearance and body area satisfaction (Miller et al. 2000). African American women scored themselves higher on both sexual attractiveness and weight concern scales, showing a higher sense of self esteem regardless of their weight (Miller et al., 2000). Miller et al. found European American women to be less self confident then the other groups.

Cultural differences are found between the African and Caucasian women in relationship to the values and beliefs about obesity (Blixen, Singh, & Thacker, 2006). These differences start with the cultural differences in the meaning of some foods and the traditions surrounding food and eating (Airhihenbuwa et al., 1996). Looking beyond these and other differences between the ways a culture views food, one gains insight to the view of obesity and weight loss. Blixen, Singh, and Thacker (2006) worked with focus groups of African American and Caucasian women with BMI > 30. The two sets of women were found to be similar in the areas of marriage, employment, and comorbid conditions, but the African Americans were slightly younger. The four focus groups generated six topics that were reviewed; 1) Attitudes and perceptions of weight 2) Areas of life affected by weight 3) Knowledge of obesity related medical problems 4) previous weight loss effects 5) barriers to successful weight loss and 6) help for primary care providers in weight-loss efforts (Blixen et al ., 2006). The attitudes of both sets of women viewed obesity as a disease over which they held little control.

African Americans have obesity taking place at much higher weights than Caucasian women. (100 pounds overweight verses 5 to 10 pounds overweight). Caucasian women hold a stronger dislike for the term 'obesity'. The areas of life affected by weight are noted to be self-image, social life and physical activity. All members reported low self-image related to their weight.

In regard to social life the Caucasian women found a greater stigma assigned to being overweight by men then the African American women. In fact the African American women felt men gave more attention to overweight and obese women. Energy was reported low in both sets with some reporting limited ability to take part in day to day activities of their family. Both sets of women reported an understanding of health issues related to obesity. In the area of weight loss attempts a marked difference was noted in the two sets, with African American women losing weight for health and Caucasian women are losing weight for appearance. Barriers to success with weight loss showed African American women with concerns related to cultural means of food along with ethnic practices related to diet and food. While Caucasian women had concerns about cultural issues, they focused more on lack of commitment on their part.

Depression was found with both sets as an issue. A marked difference was also noted in the area of what type of help they would prefer from the primary care provider. African American women asked for groups and teams of support and help. Caucasian women asked for one-on-one help from their primary care

providers. This study by Blixen et al. (2006) provides wonderful insight in to not only the cultural difference but also into gender difference and provides deeper insight in general related to the focus group format of the study.

Lerner and Korn (1972) looked at the development of body-build stereotypes in males. In their study 60 males, between the ages of 5.2 years old and 20.9 years old, were given a verbal checklist and then asked to assign the words to different pictures of boys with different body types. The results showed a 90% level of confidence. All age of boys viewed the endomorph, body shape characterized by predominance of fatty tissue, as unfavorable and the mesomorph as favorable. The boys not meeting the mesomorph standard with their own body size and shape still selected this body type as the most favored.

The study noted, "It appears that as an indirect effect of the body-build stereotypes a negative body concept is inculcated in chubby children, while in average children a positive body concept is formed" (Lerner & Korn, 1972, p. 919). Lerner and Korn (1972, p.919) did not find this to be surprising related to the "health-, youth-, and athletic oriented society."

Stigmatization and bias related to obesity play key roles in the lives of the obese (Crandall & Martinez, 1996; Kurzban & Leary, 2001; Puhl, Moss-Racusin, Schwartz, & Brownell, 2008). Stigmatization was studied in great detail by Erving Goffman from 1950 to 1960(Calhoun, 2002). Goffman viewed a stigma as a visible or invisible social distinction that disqualifies individuals or groups of people from full social acceptance.

Physical stigma includes such things as physical handicaps and obesity. Moral stigma and tribal stigma referred to such things as homosexuality and tribal stigmas that affect ethnic groups (Calhoun, 2002). Goffman's work focused on the discrediting functions of a stigma in which the individual's social identity did not meet the standards of the group and was thus incapable of fulfilling the requirement of the social group (Kurzban & Leary, 2001).

Others have put forward perceptions on stigma. Work done in 1984 by Jones, Farina, Hastorf, Markus, Miller and Scott, put forward the view of a stigmatized person being one that has been marked with dispositions that are used by others at the expense of the person's individuality (Kurzban & Leary, 2001). Thus the mark or stigma acts as a stop sign for others, keeping the stigmatized person at a distance. Researchers, Elliott, Ziegler, Altman and Scott, as presented in Kurzban and Leary (2001) analyzed stigmatization as a process that places someone outside of the protection of the social norms.

Stigmatization can lead to unfair treatment and for the obese it can take the form of bullying, harassment, and teasing (Puhl, Moss-Racusin, Schwartz, & Brownell, 2008). It has been shown that girls are more often than boys the target for stigmatization and receive more bullying and teasing about their weight (Tang-Peronard & Heitmann, 2008).

Marginalization is also more common for obese females (Tang-Peronard & Heitmann, 2008). The cost of stigmatization to the obese person has been seen in schools, work environments,

health care settings and the public at large (Puhl & Brownell, 2001; Puhl, Moss-Racusin, Schwartz, & Brownell, 2008).

Obese children were ranked as the least liked by other children in a study looking at the uniformity of reactions by children (Richardson, Goodman, Hastorf, & Dornbusch, 1961). In this study children (age 10 to 11 years old) were shown pictures of children and asked to tell the surveyor who they liked best. The obese children was rated last following: 1) a child with no physical handicaps, 2) A child with crutches and a brace on the left leg, 3) a child sitting in a wheelchair with a blanket covering both legs, 4) A child with the left hand missing, 5) a child with a facial disfigurement on the left side of the mouth (Richardson et al., 1961). These findings were true for both boys and girls, across different races and children with and without handicaps (Richardson et al., 1961). A similar study this was repeated in 2001, stigmatization was found at a higher level then the earlier studies (Satner & Stunkard, 2003). In this study 70.1% of the children rated the obese child last or second-to-last in relationship to others (Satner & Stunkard, 2003).

A study of three different age groups: prepuberty, post puberty and college-age showed a pattern of assigning positive statements for pictures of mesomorph body types (Lerner, 1969). Negative adjectives were selected for use with the picture of endomorph (Lerner, 1969). Others built on this area of study, by studying if these attitudes would be acted out in bias behaviors. Ninth grade students showed a dislike for

interaction with obese individuals, boys more so then girls (Counts, Jones, Frame, Jarvie, & Strauss, 1985). It has also been found that children in grades three to five, regardless of their own body size, selected the normal-weight space-suited individual as having the following characteristic; smarter, friendlier, better leader and working better in a group(Counts et al ., 1985). The obese may hold prejudiced views about obesity themselves (Quinn & Crocker, 1999). This is different from other stigmatized groups who gain support from others in the group.

Obese people seem to wish to distance themselves from others. Quinn and Crocker studied the relationship of strength of beliefs such as PWE and dislike of overweight others. The greater the PWE view held by the study participants the more they believed weight was controllable leading to a greater dislike for the obese person. This held true regardless of the BMI of the participants. Self identified overweight participants who endorsed PWE showed lower psychological well-being (Quinn & Crocker, 1999).

Discrimination is related to prejudice as it comes from the beliefs of the individual. It differs in that it is the actions taken by the person toward the individual or group for which they hold the bias or prejudice feelings and beliefs. Puhl, Adreyeva, and Brownell conducted a research study to compare weight/height, race and gender discrimination among U.S. adults ages 25-74. For the women in the study 10.3% reported daily or lifetime discrimination as compared to men who showed a 4.9%

rate. It is interesting to note that men with lower education had few reports of discrimination related to height/weight. Puhl et al. (2008) also noted that weight/height discrimination ranked third as the most prevalent form for women, following gender and age. It was fourth for all adults in the study, following gender, age, and race discrimination.

Discrimination was seen to be present in a study completed by Swami et al (2008). The study looked at both discrimination and stigmatization of men and women above and below the ideal body weight with a focus on being teased, lonely and viewed as lazy. Women were found to be teased and to be lonelier with BMI both higher and lower then the normal. The issue of laziness was found to be used with higher BMIs only. In looking at men, the study also used waist chest ratios (WCR) and BMI to group the responses. In the final review of data BMI was a better predictor of discrimination, following the same pattern as the women (Swami et al., 2008). Of interest in this study is the similarity of the findings between men and women. Other studies done by Hill and Silver (1995) and Kraig and Keel (2001) did not show men receiving the level of stigmatization as women (Swami et al., 2008). This may be related to the nature of the research or a shift in the cultural beliefs about the male body.

To better appreciate how obesity bias and discrimination impact lives a review of studies that have looked at discrimination in education, employment and health care will now be presented. Teachers report obese students as being more emotional, less successful with their work, and more likely to

have family problems (Neumark-Sztainer, Story, & Harris, 1999). Obese children miss more school days then average weight students (Friedman, 2008). Teachers are aware of social and self image challenges faced by students (Neumark-Sztainer et al., 1999). If students are obese at the age of 16, they have fewer years of education then non obese peers (Friedman, 2008). In the area of education, it has been shown that overweight teens received less financial support and were underrepresented in those that attend college (Puhl & Brownell, 2001).

A related study by Benson, Severs, Tatgenhorst, and Loddengaard, that bridges education and employment, involved sending a resume and a short questionnaire to public health administrators and seeking their help with career guidance. A cover letter introducing the student seeking help, pictures of the student in a normal body-build state, in an obese body-build, or no picture at all along with a short questionnaire that included the follow questions: 1) What graduate schools of public health administration would you suggest I apply to? 2) Given my background, do you think I have a good chance of getting into a public health graduate program? 3) If I get a degree in public health administration, what kind of chance do you think I'll have of getting a good job in the area of public health? It was found that in all three questions the response to the obese body-build was more negative then those responding to the normal body-build and no picture (Benson et al., 1980).

In the area of employment, overweight employees may be seen as lacking self-discipline, lazy, slower thinkers, have poor

attendance records and be emotionally unstable (Puhl & Brownell, 2001). Carr and Friedman's (2005) study showed very obese people (BMI> 35) reported job-related discrimination based on their weight. U.S. women who are obese have been shown to earn 20% less than other women (Cawley, Grabka, & Lillard, 2005). It appears that men do not share the same fate as women in terms of wages but this may be related to their selection of occupations where body size does not impact wages (Pagen & Davila, 1997). Employers have stated a desire to charge overweight employees more for health care then other employees (Friedman, 2008).

The study of bias and discrimination in health care is of major interest in view of the target audience for the educational program to follow. Health care workers share the same cultural views as others in the culture. Nurses, physicians, and other health care professionals are not without the cultural biases and stigmatizations held by the culture in which they have been raised and learned cultural norms. Patients report discrimination from health care workers in all settings, even those that focus on the care of the obese patient (Billington, Blair, Brownell, Chambliss, & Schwartz, 2003).

Health care bias was studied in 1969 by G. Maddox and V. Liederman. They wrote:

> "Moreover, the physician's reaction to overweight is said to be colored by his evaluations of the fat person as unaesthetic and morally weak. Thus, the social transaction between physicians and overweight patients appears to

reflect a complex mixture of medical fact and sociocultural values" (Maddox & Liederman, 1969, p. 214).

Their study looked at the training, experience and attitudes of physicians in regards to obesity. Using a self administered questionnaire they sought to find out the sources of information about obesity in their medical education, how they concluded that a patient was significantly overweight and success with treatment of the same. Findings showed that personal experience was the primary source of information about obesity and its management. Only 10% report successful management of obesity in their patients and they reported they preferred not to treat the obese (Maddox & Liederman, 1969).

In a self report study, doctors revealed they find obese patients as lazy, lacking in self-control, non-compliant, unintelligent, week-willed and dishonest (Friedman, 2008). Doctors spend less time with overweight patients, thus engaging in less discussion and providing less intervention (Friedman, 2008). Overweight women, in a study by Merrill and Grassley (2008) reported being dismissed by healthcare providers including not being believed and receiving no treatment for the concerns they were there to have addressed.

Hebl and Xu (2001) undertook a study to specifically examine how physicians respond to overweight and obese patients. A group of 122 primary physicians affiliated with Texas Medical Center Houston were randomly assigned to receive in the mail a packet of information containing one of six variations of medical forms much like information they would review before

meeting with a patient. These forms had information for one of the following patients: 1) average weight female 2) average weight male 3) overweight female 4) overweight male 5) obese female 6) obese male. The medical forms included the patients' history. Those patients that were overweight and obese were reported as such and all patients had a history of two migraine headaches spread out of a two-year period. The physicians were asked to complete a medical procedure form listing all the tests, procedures and referrals they would make for the patient they were reviewing along with a patient follow-up questionnaire. This form asked about time they would spend with the patient and then assessed thirteen affective and behavioral reactions that the physicians had toward the patient. Tests that were ordered revealed little difference as related to the presenting condition of the patient.

The patient follow-up questionnaire showed the physicians would spend less time with the heavier patients. The heavier the patient the more physicians identified them as less healthy, worse in caring for themselves and less self-disciplined. With this in mind it is interesting to note that physicians did not report finding the overweight or obese patients' conditions as more serious. Heavier patients were rated as more annoying, more waste of the physicians' time, and the physicians had less personal desire to help them (Hebl & Xu, 2001).

Physicians are not alone when caring for patients in a discriminatory manner. Nurses self reported viewing the obese patient as non-compliant, overindulgent, lazy, and unsuccessful

(Puhl, 2007). Some nurses also reported they are uncomfortable caring for obese patients (Marhoney & Golub, 1992). Repulsed was a word used to describe how nurses felt about obese patients in a study done by Bagley et al. (1989). Psychologists find obese patients to have more pathology, more severe symptoms and worse prognosis for recovery (Puhl, 2007).

Obese patients' satisfaction with health care is important to understand related to the goal of providing better care to this patient group. Many factors come into play in relationship to patients' reported level of satisfaction. These factors include elements of the physical environment where they are seen. For example, obese patients need to be comfortable with the seating provided in waiting and exam rooms (Merrill & Grassley, 2008). The availability of equipment such as blood pressure cuffs, gowns and scales is also important (Merrill & Grassley, 2008). Obese patients also report noting where they are weighed and the facial reaction of those weighing them as factors in satisfaction (7B patient, who did not wish name recorded, personal communication, 11/01/2008).

Body language conveys messages we are often unaware of, yet body language is 55% of all communication (Thompson, 2007). Biases held, stigmas supported, and discrimination performed are also communicated to others without awareness of the professional care giver. It is only in understanding communication to this level that changes for the better can be made in how care is given to obese patients.

Puhl, Moss-Rascusin, Schwartz and Bronwnell (2008, p.352) study asked those in the study this question, "What would you like others to know about what it is like to be overweight or obese?" The responses were grouped into three themes and are included in the table below along with the top 5 responses for each grouping.

Table 1

What would you like others to know about being overweight?	**Percentage of individuals endorsing responses**
Weight Based Responses:	
Difficulty of weight loss	35.8
Physical challenges of excess weight	16.4
External attributions of blame	15.1
Obesity has a complex etiology	15.1
Food is addictive	9.1
Consequences of Stigma:	
Depressive feelings	18.6
Relationship suffered	7.5
Feelings hurt	6.3
Humiliation/embarrassment	5.7
Sadness/sorrow	5.3
Challenging Stereotypes:	
Do not judge me based on appearances	10.1
I do not overeat/binge	9.1
I have feelings too	9.1
I am a good person	8.5
I do not want to be heavy	8.2

(Puhl, Moss-Racusin, Schwartz, & Brownell, 2008)

The answers provide caregivers a view of what the obese patient would share if given the opportunity and relationship to do so. One study of patient satisfaction found that the obese patients showed greater satisfaction than normal weight counter parts (Fong, Bertakis, & Franks, 2006). The study listed a wide range of reasons this finding may be true, including low expectations based on social harshness experienced by obese individuals(Fong et al ., 2006). Should the goal of health care not be to provide a level of care to these patients that would be high in patient satisfaction not because they are treated slightly better then they are treated in the general public but because they are treated with outstanding respect and compassion?

Chapter 3 Educational Program

To better prepare health care professionals caring for obese patients, an educational program has been developed using Leininger's Transcultural Nursing Theory. Before one can learn about other cultures and help people in different cultures, one most 'Know thy self.' This is the first important principle of transcultural nursing according to Madeleine Leininger (Leininger & McFarland, 2002). All health care workers can add to their knowledge and ways of caring by understand this key concept of the Sunrise Model of Nursing Care. This is the reason when caring for the obese patient it is important to look at the overriding cultural views of obesity and the subculture of the obese patient. These form the foundation for the proposed educational program. Other knowledge from the literature review will also serve as a base for the education program. These include:

- Defining principles of Transcultural Caring
- History of obesity
- Key cultural concepts about size
- Review of work on media influences by Gunther and Park
- Cautions about assumptions in relationship to how the patient views their own obesity
- How bias and stigma are played out
- What can we do to improve care

Culture is learned from stories and behaviors of those around us. Patient experiences and stories along with small group

interaction will be used as the means of explaining this important cultural issue.

The model is designed for classroom or presentation in which the group size would be limited to 15 to 30 people. Auditions could be health care students and working health care professionals. The setting would allow for the large group to break down into smaller groups of not less then 4 to 5 people. This is important related to the need for members of the small groups to feel comfortable with talking about their own experiences and view of obesity. PowerPoint with video capacity or some other means of showing video would be required. Handouts and worksheets used for small group work are also required. Handouts would include the reference lists form this paper. Work sheets will include direction for the table based activities. Length of the program is approximately 90 minutes. The program will be made available to the education department at the University of Minnesota Medical Center for use with present and newly hired staff. It will also be shared with the Bariatric Surgery Physicians with the University of Minnesota Physician Group for their use. Other audiences for the program may include The National Association of Bariatric Nurses. The following material includes primary talking points and patient stories along with questions for small group exercises. This program could be adjusted at the request of the sponsor of the education to meet the needs of the intended audiences. For example the presentation for a mixed group of care professionals should be different from a presentation for a group of nurses.

Program Objectives

At the completion of this program health professionals attending will:

- Recognize the role of culture in how obesity is viewed in America today.
- Understand prevalence of bias, stigmatization and discrimination facing obese patients in the different areas of their lives.
- Develop at least one action they can take to address the cultural needs of obese patients they care for.

Program agenda:

I. Introductions and welcome. (5 minutes)

II. Basics of Leininger's Transcultural Model of Care. (10 minutes)

III. Cultural messages about obesity. (Lecture and small group exercise) (25 minutes)

IV. Bias, stigmatization, discrimination faced by the obese patients: home, school, work and healthcare. (25 minutes)

V. How health care can be improved for obese patients. (Lecture and small group exercise) (20 minutes)

VI. Summary and challenges remaining (5 minutes)

Program talking points

I. Introduction

a. Purpose of presentation

b. Agenda and Schedule

II: Basics of Leininger's Transcultural Model of Care

a. Defining culture and how it is learned and shared:

"Culture is defined as the learned and shared beliefs, values, and lifeways of a designated or particular group that are generally transmitted intergenerationally and influence one's thinking and actions modes" (Leininger & McFarland, 2002, p. 9). Cultural norms, beliefs and behaviors are learned. No one comes into the world knowing such things as how to greet an elder, what foods are eaten on a celebrated holiday or even what holidays are celebrated, or how to show caring for others. These are things that are learned. Not learned from a book in most cases but learned from the people who surround us, in the stories they tell and the behaviors they show. In today's world the messages of the media, television, movies, print media, and internet have become part of what surrounds us.

B. Why is this important to understand in relationship to the care of the obese patient?

Madeleine Leininger's Transcultural Nursing Theory is built on the framework of including the patient's cultural beliefs and experiences into what type of care and how care is provided to them. Caring is a natural part of all cultures. In caring for all patients it is necessary to understand the beliefs the patient holds and how their experiences in their culture has framed who they are and how they see themselves. For example in a Namibian family the cultural expectation is that the daughter would provide care for her father as he grows older and becomes unable to care for himself. No one else in the family is as able to provide this care as her (Leininger & McFarland, 2002).

In traditional Hmong culture the use of opium is not illegal or viewed as a problem as long as the person using it fulfills their other duties to the family. In the case of the obese patient, culture is important in relationship to how they see themselves and how they believe those around them see them.

III: Cultural Messages about obesity

A. Groups of four to five people will be formed. Each group will be asked to think of three or more messages from one of the following areas that influence and form their own beliefs about eating and obese people.

1. Messages from family members and family rituals.
2. Messages from friends/peers and at what age these messages are first received.
3. Messages from the media. (Print, television, movies, music, internet)

B. Groups will be asked to report their work to the large group and ideas will be recorded on flip charts for all to see. Information on the following areas would be added as necessary to ensure a well rounded picture of cultural messages is covered.

1. History
2. Protestant Work Ethic
3. Crandall and Martinez's research on the different views of Mexicans and Americans (Crandall & Martinez, 1996)
4. Gunther's research on media's affects on my view and the view of others (Gunther, 1998)

5. Park's review of how people will remain silent if they feel their view is different then the majorities' view of an issue (Park, 2005)
6. Development of body image and body shame including work by Bruch, 1997; Gilbert & Miles, 2002; Miller et al., 2000.
7. Work by Staffieri related to children's selection of body types (Staffieri, 1967)
8. Review of media images using *Shallow Hal*

The obese in America continue to hear jokes about their size on television and in movies. Based on the work of Elliot, Ziegler, Altman, and Scott this may still be socially tolerated related to the obesity stigma allowing the obese to be treated as if they are unworthy of the protection of being politically correct (Kurzban & Leary, 2001). *Shallow Hal*, a 2001 film directed by Bobby Farrely and Peter Farrely, tells the story of a man who thinks beauty and size are the most important elements of a woman until he is hypnotized to be able to see the interior beauty of women (Moynihan, Farrelly, & Farrelly, 2001). The film is filled with situations that point to the failings of the obese woman he falls in love with. From breaking chairs to eating too much the film uses situational and physical comedy to highlight the size of the character played by Gwyneth Paltrow. Some may call this a film that examines the short sightedness of the main character, Hal, but others may see it as approval to make fun of the obese. Either view may match your own however; you need to remember others may see it differently based on

their own culture view of the subject and their life experience with the issue of obesity.

IV. Bias, Stigmatization, Discrimination Faced by Obese Patients

A. Define terms:

1. Bias: Distortion or preconceptions of who a person is based on a cultural stereotyping or experience (Calhoun, 2002).
2. Stigma: Defined by Erving Goffman, principle sociological theorist, as Stigma are visible or invisible social distinctions that disqualify individuals or social groups from full social acceptance. These stigmas can be physical or moral in nature (Calhoun, 2002).
3. Discrimination: Takes place when people take actions on bias and stigma to the harm of the individual or group to which they are held.

B. Examples will be presented using the following examples from people's stories and research.

1. Family

a. "My father was always telling me I was fat because I was lazy. I have always been active but I didn't participate in athletics in school. I was in marching band, chorus and other more academic pursuits so therefore I was 'lazy'. To this day I feel guilty if I sit down to read a book or magazine" (Puhl, Moss-Racusin, Schwartz, &

Brownell, 2008, p. 351). This statement was made by a 75 year women.

b. "My mother telling me in a loud voice at a family gathering that I should buy my clothes at the tent and awning supply store. (57 year old female)(Puhl et al ., 2008, p. 351)

c. "I remember sitting on a stool in the Chubby Department of Lane Bryant when I was seven years old and my mother said that me that I had outgrown the biggest chubby size and she could kill me because now at the age of seven she'd have to get me clothes in women's size (Millman, 1980, p. 10).

2. School:

a. "They weren't being friendly when they offered you cookies. They don't look at you the way we see ourselves. Thin people look at us differently. They don't understand us. When they offered you food it was like offering food to the animals at the zoo. They are offering you food as a big joke and they are laughing at you, not with you (Millman, 1980, p. 60).

b. Study by Neumark-Sztainer, Story, and Harris (1999), on the beliefs and attitudes of teachers about obese adolescents.

c. Information from Friedman's (2008) work on bias in educational settings.

3. Work:

a. Benson, Severs, Tatgenhorst, and Loddengaard (1980) study on the social cost of obesity will be reviewed.

b. Information from Cawley, Grabka, and Lillard (2005), Friedman (2008), and Pagen and Davila (1997) on earns of obese as compared to others will be reviewed.

4. Health Care:

a. "I think the worst was my family doctor who made a of habit of shrugging off my health concerns…The last time I went to him with a problem, he said, 'You just need to push yourself away from the table'. It later turned out that not only was I going through menopause, but my thyroid was barely working. (63 year-old-female)(Puhl, Moss-Racusin, Schwartz, & Brownell, 2008).

b. Examples of what is said and what patients understand it to mean:

"Go get the C.O.W." (Computer on wheels)

"Let's get the troops to get her up."

"We'll need the Big Boy bed for this one."

c. Hebl and Xu (2001) study related to physicians plan for three different groups

Cultural view of obesity

of patients: average weight, overweight and obese, including physicians self report on how they feel about working with obese patients.

d. Information from Friedman (2008), Billington, Blair, Brownell, Chambliss, and Schwartz (2003), Marhoney and Golub (1992), Puhl (2007), on bias and discrimination found in health care will be presented.

e. Equipment needs.

V: How to Improve Care of the Obese Patient.

A. Each table will be given 10 minutes for developing at least three actions that would improve health care for these patients. These will be reported back to the large group and recorded for group review and discussion.

VI: Summary and challenges:

Lynn McAfee, a speaker on obesity gives us these two quotes

- "Many of us (the obese) hate our bodies so much we think they don't deserve to feel good or to be taken care of." (McAfee, 1998, web site)
- "No matter why we are fat, right now we exist. And we deserve the best possible medical care just as anyone else is who is another size."

(McAfee, 1998,web site)

Evaluation of the program would be done by the members of the audience following the education. Two of the key questions on the evaluations will ask if they have a better understanding

of the cultural bias, stigmatization, and/or discrimination faced by obese people in the country and to define at least one strategy they can use in their work to improve the care of the obese patients they serve.

Chapter 4 Discussion

The causes of obesity are complex and treatments available to those with obesity are many. Obesity has been a culture issue for mankind going back to Socrates and the Spartans. Unlike anorexia nervosa, obesity is not in and of itself considered a psychological illness. Like anorexia nervosa it is not easily understood. Obesity has many affects on the wellbeing of humans including the physical illnesses of hypertension, diabetes, heart disease, and sleep apnea. It can also lead to body shame, poor self image, and depression. Treatments for obesity may be able to reduce the individual's weight but treatment alone will not erase the experiences of being obese in our culture.

To be obese in this culture means that you will hear about the wonders of weight loss programs. You will hear repeated messages about how thin is better for your health and your social life. You may even hear, "but she has such a pretty face." "Super-sized" meals high in fats and calories are all around you. You may be the last one picked for the team in school gym. Research has shown obese women earn less money. Discrimination may be a fact of life if you are obese here in the U.S. Discrimination has been found within families, school settings, work places and health care.

Discrimination is seen within health care services at all levels. Leininger's concept of including cultural understand in the care given provides hope that health care services can be

improved. Health care workers need to understand their own views on obesity before they can evaluate and change their own behavior. Nursing is key in addressing this health care challenge.

Those working in transcultural nursing, though education and research, are in position to become advocates for the obese patient. In reviewing the work done by Leuining, Swiggum, Wiegert, and McCullouhg-Zander on the proposed standards for transcultural nursing, promotion of improved health care for obese patients is clearly within the scope of transcultural nurses (Leuning et al., 2002). The standards for transcultural nursing include skills for holistic assessments of patients, families and the community. These skills are critical for obese patients, as they will provide a picture of how the patient functions within the family and the community. Problems such as depression, withdrawal for activities outside the home or complete isolation would be identified. Assessment such as this could also identify any past concerns related to health care treatments and care received.

Transcultural nurses are in outstanding position to educate other nurses and health care workers on the affects of bias and discrimination for obese individuals. This education may be formal in nature such as in the classroom or in seminars. The informal education will take place when leading by example. Obese patient wish to receive caring and acceptance for who they are, not what size they are. It has been shown that when people work together in a structured way to solve shared problems their

attitudes about diversity can change dramatically (Teaching Tolerance, 2008). This is a mandate for transcultural nurses.

There is also need for research on the care of obese patients. Many of the studies done related to health care bias are more the five years old. As more individuals in American become obese, it will be imperative to understand the challenge they face in receiving quality health care. Research like that done by Puhl, Moss-Racusin, Schwartz and Brownell in which they provide a forum for patients to share what was important for others to know about being obese, may perhaps be the most powerful in changing health care delivery. For it is in knowing more about the culture of the obese patient that care can improve.

Chapter 5 Conclusion

Obesity is not only a physical illness and can no longer be treated or viewed as such by health care professionals. As early as 1948 this was clear to Hilda Bruch who saw the need to view an obese patient as more then merely a person of size. Eating in all cultures serves more than the uncomplicated propose of meeting caloric needs of the body. Eating is related to pleasure in taste and the emotions in the gathering of people for celebrations. Chicken soup and many other foods are known as comfort foods. Those with overeating problems can not simply go to treatment for addiction.

The research reports cultural challenges faced by obese patients on a daily basis. Reminders of the cultural view of the obese surround them. As professionals who work with obese patients and who will likely work with more obese patients if the national tread toward obesity is not put to an end, it is imperative to understand not only the physical issues surrounding obesity but also the psychological and cultural issues. For if we only treat the issue for weight loss with physical treatments such as restrictive diets, medications, and surgeries we will have failed to truly treat the obese patient.

Culture makes us who we are and is part of how we see the world around us. If health care professionals continue to fail in their understanding of this cultural influence obesity will face the human race for years to come. Education on the importance of culture in the care of obese patients is paramount

to the treatment of this condition. History has told us this; research has proved it and now it the time to act on these lessons. Transcultural nursing has provided us the means to confront the problem with a hope of success.

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